STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	07/21/2011

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WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVENUE INDIANAPOLIS, IN46227

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20 & 21, 2011 Facility number: 000537 Provider number: 155409 AIM number: 100267270 Survey team: Marcy Smith, RN TC Leia Alley, RN Barb Hughes, RN Karina Gates, Medical Surveyor Census bed type: SNF/NF: 49 Total: 49 Census payor type: Medicare: 6 Medicaid: 39 Other: 4 Total: 49 Sample: 13 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2. Quality review completed on July 27,	F0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2011 by Bev Faulkner, RN			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on record review and interview, the facility failed to ensure the location and intensity of residents' pain was assessed prior to administering an as needed pain medication and failed to conduct a followup assessment to determine the effectiveness of the pain medication for 3 of 12 residents assessed for receiving pain medications in a sample of 13. (Residents #13, #44 and #8) Findings include: 1. The record of Resident #13 was reviewed on 7/20/11 at 12:40 p.m. Diagnoses for Resident #13 included, but were not limited to, altered mental status, external hip fracture and foot ulcer. Recapitulated physician's orders for July, 2011, indicated the resident could receive Tylenol 650 mg. (milligrams) every 4 hours as need for mild pain (original order	F0309	**F309–** It is the intent of the facility for nursing to assess and identify the location and intensity of a resident's pain prior to administering an as needed pain medication and to conduct a follow-up assessment to determine the effectiveness of the pain medication. **1. ACTIONS TAKEN:** A. In regards to Resident #13, the resident was discharged from the facility on 7-22-2011. B. In regards to Resident # 44, a new pain assessment was completed to determine effectiveness of the current pain regimen. C. In regards to Resident # 8, a new pain assessment was completed to determine the effectiveness of the current pain regimen. **2. OTHERS IDENTIFIED:** A. 100% pain audit of all residents currently receiving pain medication to ensure their current pain regimen is effective. No other residents were identified. **3. SYSTEMS IN PLACE:** A. All nursing staff in-serviced on 7-28-11 for appropriate	08/20/2011

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	date 6/4/11) and Oxycodone-Apap 5-325 mg., 1 tablet every 4 hours as needed for pain (original order date 6/2/11). Review of the Medication Administration Record (MAR) for June, 2011, for Resident #13 indicated she received the Tylenol on 6/5 at 12:00 (a.m. or p.m. not indicated), 6/9 at 10:00 a.m., and 6/17 at 2:00 p.m. and 8:00 p.m. Review of the same MAR for June, 2011 indicated the resident received Oxycodone on 6/6 at 3:00 p.m., 6/11 at 8:00 a.m., 4:00 p.m. and 8:00 p.m. There was no documentation found on the MAR or in the nurses' notes to indicate the location of the resident's pain or how severe it was. Further information was requested from the Director of Nursing (DoN) on 7/20/11 at 4:30 p.m., regarding nursing assessment of the location and severity of Resident #13's pain prior to administering her pain medication. On 7/21/11 at 9:35 a.m., the DoN indicated "I have no response for that." A care plan for the resident indicated a problem of "Resident is at risk for uncontrolled discomfort due to hip fracture," dated 3/24/11. Interventions		assessment of pain; determining location and severity of pain; and appropriate documentation of pain. In-serviced on follow-up of effectivenessof pain medication and appropriate documentation. Another in-service will be provided on 8-12-11. **4. HOW MONITORED:** A. The D.O.N./Designee will complete a daily QA Audit X 30 days; then weekly X 60 days; then monthly for 90 days; to ensure the pain assessments and appropriate follow-up are completed and documented for any resident receiving pain medication. B. The CEO/Designee will review all QA audit as completed in daily QA stand-up meeting. C. The CEO/Designee will review monthly in QA meeting;and quarterly in QA meeting with the Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: August 20, 2011.**	

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	included but not limited to, "...4. Give as need pain medications as ordered...6. Review and adjust pain medications [with] MD/NP [nurse practitioner] as needed..." 2. The record of Resident #44 was reviewed on 7/19/11 at 8:45 a.m. Diagnoses for Resident #44 included, but were not limited to, acute kidney failure, morbid obesity, schizoaffective disorder and chronic airway obstruction with tracheostomy. Recapitulated physician's orders for July, 2011 indicated the resident could receive Tylenol 650 mg. 1 tablet every 6 hours as need for pain (original order date 5/11/11). The MAR for June, 2011, indicated Resident #44 received Tylenol on 6/1 at 6:00 p.m., 6/3 at 3:00 a.m., 6/11 at 4:00 p.m., 6/15 and 5:00 p.m., 6/20 at 5:00 a.m. and 6/25 at 4:00 p.m. There was no documentation found on the MAR or in the nurses' notes to indicate the location of the resident's pain or how severe it was. Further information was requested from the Director of Nursing (DoN) on 7/20/11			

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	at 4:30 p.m., regarding nursing assessment of the location and severity of Resident #44's pain prior to administering her pain medication. On 7/21/11 at 9:35 a.m., the DoN indicated "I have no response for that." A care plan for Resident #44 indicated a problem of "Resident is at risk for episodes of uncontrolled discomfort..." Interventions included but were not limited to "...4. Give as needed pain medications as ordered...6. Review and adjust medications as needed..." 3. The clinical record for Resident #8 was reviewed on 7/20/11 at 10:30 a.m. Resident #8's diagnoses included, but were not limited to: Parkinson's Disease, Depression, Seizures, Constipation, and Dementia. The July, 2011 physician's recapitulation order indicated Acetaminophen 325 mg to be given every 4 hours PRN (as needed) for pain with an original order date of 1/25/11. The June, 2011 MAR (Medication Administration Record) and July, 2011 MAR were reviewed on 7/20/11 at 10:45 a.m. They indicated Resident #8 was given Acetaminophen 325 mg on June 9, 2011 at 8:00 a.m., June 23, 2011 at 6:00			

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	a.m., June 28, 2011 at 5:00 p.m., and July 8, 2011 at 3:00 a.m. There was no documentation on the MAR or in the nurses' notes to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given. Resident #8's care plan for pain was reviewed on 7/20/11 at 11:15 a.m. It indicated nursing is to give PRN medication as ordered and to follow up with effectiveness of medication. During an interview with the Director of Nursing on 7/19/11 at 3:00 p.m., she indicated when giving an as needed pain medication the nurses should assess for appropriate need, try other interventions prior to giving the medication, document that the medication was given and do a follow up to see if the medication was effective. This should be documented on the medication sheet or in the nurses' notes. 3.1-37(a)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was covered while stored in the freezer, opened containers of sour cream were properly labeled with open dates, and hot dog buns were stored in a manner not conducive to mold production. This had the potential to affect 49 of 49 residents at the facility who consume foods served out of the kitchen. Findings include: On 7/18/11 at 9:45 a.m., a tour of the kitchen was conducted with the Dietary Manager. During observation of the dry storage room, three packages of 8 count hot dog buns were found with a best by date of 7/12/11. One pack of the hot dog buns was found to have a green mold looking substance on one of the buns. The Dietary Manager removed the 3 packages of hot dog buns from the dry storage	F0371	**F371** – FOOD PROCURE, STORE/PREPARE/SERVESANITARY. It is the intent of the facility to ensure food is covered while stored in the freezer; open containers are dated with open dates; and hot dog buns are stored in a manner to prevent mold production. **1. ACTIONS TAKEN:** A. All identified food items were immediately removed from the storage areas and discarded. DM audited all storage areas for proper storage and dating of items when opened. **2. OTHERS IDENTIFIED:** A. All residents would have the potential to be affected. **3. MEASURES IN PLACE:** A. All Dietary Staff were in-serviced on 8-11-11 regarding the proper guidelines for food storage in the freezer/refrigerator; marking the date an item is opened; and adherence to proper rotation and/or disposal of outdated bread. **4. MONITORING IN PLACE:** A. DM/Designee will do random audits daily in regards to proper storage in the freezer/refrigerator,	08/20/2011

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	room. During interview with the Dietary Manager on 7/18/11 at 10:15 a.m., she indicated all bread is used on a first in first out method and the hot dog buns were overlooked. During observation of the freezer, a pan of uncovered brussel sprouts was stored on the bottom shelf. The Dietary Manager removed the brussel sprouts from the freezer. During observation of the refrigerator, two containers of opened sour cream were found with no open or use by date. The Dietary Manager removed both containers of sour cream from the refrigerator. The Date Marking Policy provided by the Dietary Manager on 7/21/11 at 3:45 p.m., was reviewed on 7/21/11 at 4:00 p.m. The policy indicated expiration dates on commercially prepared, dry storage food items will be followed. It also indicated the individual refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage location and once opened, potentially hazardous food will be re-dated with a use by date. 3.1-21(i)(2)		items dated when opened; and proper rotation of and/or disposal of outdated bread. B. The CEO/Designee will monitor weekly for proper storage in the freezer/refrigerator; items dated when opened; and proper rotation of and/or disposal of outdated bread. C. The CEO/Designee will review all audits as They are completed in the daily QA stand-up meeting;Monthly in the QA meeting; and quarterly in the QA meeting with the Medical Director. **5. This plan of correction constitutes our credible Allegation of compliance with all regulatory Requirements. Our date of compliance is: August 20, 2011.**	

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F9999	3.1-21(i)(3) 3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment or, within 30 days for personnel assigned to the Alzheimer ' s and dementia special care unit, and three (3) hours annually thereafter to meet the needs, or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 8 of 14	F9999	**STATE TAG #9999**: **PERSONNEL** It is the intent of this facility for all employees to receive 3 hours of dementia training annually. **1. ACTIONS TAKEN :** A. Employees # 3; # 4; # 6; # 9; # 10; # 11; # 13; and # 14: an additional hour of dementia specific training will be provided to complete the annual three hour requirement. **2. OTHERS IDENTIFIED:** A. 100% audit of all employee records for 3 hours of dementia specific training annually. An in-service will be provided on 8-16-11 for any employees identified. **3. MEASURES TAKEN:** A. All mandatory in-services/training and education will be scheduled on an annual basis; including a quarterly dementia specific training (a minimum of one hour in length). Attendance will be made mandatory and will be monitored. **4. HOW MONITORED:** A. Human Resources/Designee will	08/20/2011

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	employees hired before June, 2010, received 3 hours of dementia training annually. (RN ' s # 3, #6, LPN ' s # 4, #10, CNA #9, Cook #11, Activities Director #13, Maintenance #14) Findings include: Employee files were reviewed on 7/21/11 at 9:00 a.m. The following employees files did not include the required dementia training. RN #3 was hired on 1/12/10. There was documentation of 2 hours of dementia training within the last year. LPN # 4 was hired on 3/16/10. There was documentation of 2 hours of dementia training within the last year. RN #6 was hired on 1/26/10. There was documentation of 2 hours of dementia training within the last year. CNA #9 was hired on 5/13/2004. There was documentation of 2 hours of dementia training within the last year. LPN #10 was hired on 9/8/2009. There was documentation of 2 hours of dementia training within the last year. Cook #11 was hired on 3/23/1995. There was documentation of 2 hours of dementia training within the last year. Employee #13 (Activity Director) was		audit/monitor all in-service attendance and will audit employees files quarterly to ensure completion of mandated dementia specific in-services. . B. CEO/Designee will review all audits as completed at QA stand-up meeting; monthly in QA meeting; and quarterly in QA meeting with the Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: August 20, 2011.**	

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	hired on 4/26/2010. There was documentation of 2 hours of dementia training within the last year. Employee #14 (Maintenance) was hired on 1/4/2010. There was documentation of 2 hours of dementia training within the last year. Employee In-Service records were reviewed on 7/21/11 at 2:30 p.m. The records indicated that dementia in-services were held on 9/10/10 and 4/9/11. During an interview with the Facility Administrator on 7/21/11 at 3:30 p.m., she indicated that there were no other in-services within the last year for dementia and that each in-service conducted was approximately 1 hour in length. 3.1-14(u)			